

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0603	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2012
NAME OF PROVIDER OR SUPPLIER CLEVELAND CARE & REHABILITATION CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 2750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments An licensure survey and complaint investigation #30519, were completed on October 10, 2012, at Cleveland Care and Rehabilitation Center, No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

Administrator

10-30-12

6699

QLP911

If continuation sheet 1 of 1